Reducing the Cost of Institutional Care: Downsizing, Diversion, Closing and Conversion of Nursing Homes

Prepared by

Julie Fralich
*Muskie Institute of Public Affairs
University of Southern Maine*

Trish Riley
Robert L. Mollica
Kimberly Irvin Snow
Deborah J. Carr
*The National Academy for State Health Policy*

Susan McDonough
*Lanzikos, McDonough & Associates*

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50 Monument Square, Suite 502
Portland, Maine 04101
Phone [207] 874-6524

University of Minnesota
IHSR, School of Public Health
420 Delaware St., S.E., Box 197
Minneapolis, MN 55455
Phone [612] 624-5171

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Preface

An earlier version of this paper was developed for a meeting sponsored by the University of Minnesota/National Academy for State Health Policy National LTC Resource Center entitled The Cost of Institutional Care: How to Get Around the Roadblock to Medicaid Reform. This meeting was a preconference presentation at the Academy’s 1994 conference, Health Reform Under Construction: States at Work, held in Burlington, Vermont. The paper describes the complex issues facing state officials who are seeking strategies to shift resources from institutional to residential and community based long term care services. We are grateful to the faculty of our preconference for their contributions which we have synthesized in the text.

The opinions here are those of the authors and should not be construed as representing the Administration on Aging, the University of Minnesota or the National Academy for State Health Policy.

Trish Riley, Co-Director
National LTC Resource Center
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Reducing the Cost of Institutional Care: Downsizing, Diversion, Closing and Conversion of Nursing Homes

Executive Summary

Medicaid today pays for 41% of the nation's long term care bill. Most of that spending (85%) is on institutions. As the Congress grapples with efforts to reduce Federal expenditures and balance the budget, the Medicaid program and its investment in long term care are particularly vulnerable to cuts. Indeed, Medicaid comprises nearly half of the total Federal government spending on entitlement programs for the poor and therefore will likely see reductions no matter how Congress elects to deal with the program (e.g.: Federal cap, block grant, Federal "take over").

Distribution of Federal Means-Tested, Entitlement Spending, FY1994

- Other Programs*: 9%
- Earned Income Tax Credit: 6%
- Food Stamps: 14%
- SSI: 14%
- AFDC: 10%

Total Means-Tested Entitlements = $177 billion

*Include the school lunch program, student loans, and veteran's benefits.

Because Medicaid is a shared Federal/state program with states paying about 43% of total costs, should Federal cuts materialize, states will need to look hard at current spending. Regardless of Congressional actions, states are struggling with how best to constrain Medicaid costs and meet growing demand. In 1992, institutional care accounted for 29% of total expenditures, while only about 5% of recipients used these services. As institutional costs become a target for budget-cutters, consumers
increasingly seek non-institutional options for care. Consumers increasingly seek non-institutional options, institutional spending is a likely target for cuts.

**Medicaid Expenditures by Service, 1992**

- Hospital Inpatient: 19%
- Outpatient: 7%
- Physician, Lab, X-ray: 6%
- Prescription Drugs: 5%
- Other Acute: 5%
- ICF-MR: 8%
- Mental Health: 2%
- Home Health: 5%
- Other*: 20%

Total spending = $113 billion

*Other includes payments to Medicare, payments to HMOs and Disproportionate Share Payments


Home and community-based waiver programs have shown that states can provide nursing facility level care at home for the same or below the cost of nursing facility care. Currently, these programs comprise only 3% of total Medicaid outlays. Consumers overwhelmingly prefer to remain in the community rather than enter the nursing home for care. With the reality of these dual fiscal and consumer imperatives, it seems that states ought to be able to shift the resources from the institution to the community. But doing so is often more difficult than it seems. Why? Fear of political repercussions from the nursing home industry and local communities, worry about disruptions to consumers and providers, uncertainty about the potential increased demand for community care, and insufficient penetration of community-based services are four major reasons why long-term care reform is so hard to achieve. This paper was written prior to the current Federal debate, but provides a summary of strategies that states have used to redirect the flow of resources from the institution to the community options that consumers want.

One of the strongest fears facing policymakers is that of a political backlash from the nursing home industry. Nursing homes in many communities are major employers and provide a service that the public values. The threat of downsizing or closure due to government intervention can spawn public outrages from both voters and lobbyists. The 1980 Boren Amendment to the Social Security Act requires
Medicaid reimbursement be “reasonable and adequate” to meet the costs of “efficiently and economically” operated facilities. States attempting to reduce outlays on institutional care through reducing reimbursement rates can find themselves embroiled in lawsuits over this amendment. But some states have faced the fear of political conflict and have implemented strategies to limit the flow of resources to the institution through means other than reducing rates.

Through capping or reducing the number of beds available, states hope to reduce the dollars that go to nursing homes. This aggressive tactic changes the way that nursing homes can operate through restricting their ability to grow. Reimbursing nursing homes for specific occupancy rates that encourage facilities to take their beds “off line” also affects the industry, but it allows facilities the option of using their beds at a later time or in a different part of the state. The “buy back” of beds that have already received certificate of need approval is another way that states have confronted the problem of too many resources going to the institution. These strategies have caused political and legal repercussions. States must remember that nursing facilities are largely private businesses or voluntary nonprofit organizations, and legal issues such as the “taking of property” become relevant when the government buys back beds or closes facilities. However, policy makers in the states that have tried these approaches have voiced their commitment to reforming the long term care system so it is more affordable to the state, and so, to its citizens. With this commitment, policy makers can temper the ill-effects from such bold moves and can learn from the experiences of the states which closed mental health institutions described in the paper.

Worry over disrupting consumers and providers also contributes to the difficulty of redirecting resources. For example, changes in Medicaid functional eligibility criteria for nursing home care can result in denials of admission to the institution. States are concerned that if appropriate home care services are unavailable in the community, some recipients may not receive enough care. Some states may be afraid that changes in the availability of nursing facility services will create underservice for those who require intensive care. But others note that Medicaid waivers and state programs have targeted nursing home eligibles and proven they can be served safely at home and in residential settings. Case management can be used to help consumers find and receive the long term care services they need in the community rather than entering the nursing facility. Pre-admission screening programs also ensure that the people who can be served in the community are not placed in the institution. Tightening the medical eligibility criteria for nursing home placement is another way to ensure that only the most severely disabled people are admitted to the nursing home. And changes in law, such as the Nurse Practice Act, free nurses to delegate responsibility to others where they see fit, allowing services to be provided in the home setting at a lower cost. Through diverting consumers to other usually less costly services, states have decreased the demand for nursing home services and increased that of home and community based services.
Many states are reluctant to encourage greater development of home and community based services because they fear that more consumers would select to use home care than agree to enter a nursing facility. Under the threat of a growing population in need of long term care, some states are afraid that if more community services are available, people “will come out of the woodwork” to use them, costing the state more resources. Other states view this dilemma differently. Through encouraging the development of community services, states anticipate a phased reduction on the reliance of nursing home care, and the concomitant availability of “new” dollars for home care. States are preparing for the increased need for long term care by beefing up those services that can meet the need at a lower cost than nursing facility care. As consumers choose these services, nursing facilities will experience a decrease in demand, and will, likely, take some of their beds off line themselves.

The strategy to increase home and community based care in order to reduce the demand and supply of nursing home care requires that these services be cost effective and that a sufficient range and availability of service and housing alternatives. States that encourage the development of assisted living try to alleviate this problem by increasing housing options. Nursing facilities are also interested in changing their product lines to meet consumer preferences, and so have shown interest in converting parts of their facilities to assisted living units. Conversion of nursing facilities seems to be a natural way for states to work with the nursing home industry to redirect the flow of resources. However, the process of conversion is not easy for facilities or policy makers. Nursing facilities may not be able to create a meaningful difference between life in the assisted living wing and life in the nursing home wing. This strategy may minimize the political backlash through encouraging the nursing home industry to develop product lines that consumers want. However, policy makers also need to ensure that the new product lines meet what consumers need from assisted living. Conversion raises serious policy questions for states to assure such strategies do more than create nursing homes by another name.

All of these approaches test the mettle of policy makers as they focus on segments of the system to achieve a reduction or redirection of resources from the institutional setting. Changing the flow of resources, while necessary to achieve long term care reform, often leads to political strife. States face the challenge of changing the status quo of institutional bias while limiting ill-effects on consumers and local economies. This paper does not advocate one strategy over another, but it does describe a number of successful efforts made by states to achieve a more reasonable distribution of long term care resources.
I. Introduction

Since the beginning of our nation's history, the institution has been the place where people in need could receive public assistance to meet their needs. Initially, the poor farm or almshouse provided public assistance and by 1920 70% of the residents were elderly. The creation of Medicare and Medicaid and the availability of direct vendor payments to nursing homes, fueled their growth. In the 1960s, Federal government policy furthered the development of nursing homes through investments in Hill-Burton, the Small Business Administration and the Federal Housing Act, all of which supported the development of nursing homes. Yet the majority of people who need long term care do not live in institutions. It is estimated that 12 million Americans need long term care services, but only 2.4 million of these people live in institutions. Most live at home or in small community residences.

While consumers repeatedly seek home care and residential, non-institutional options for care, the institutional bias continues in today's Medicaid program. Medicaid pays primarily for nursing homes. Indeed, in 1993, elderly and disabled recipients comprised 27% of the nation's Medicaid beneficiaries but accounted for more than 67% of Medicaid's expenditures.

Chart 1: Medicaid Expenditures and Beneficiaries, 1993

<table>
<thead>
<tr>
<th>Medicaid Expenditures by Enrollment Group, 1993</th>
<th>Medicaid Beneficiaries, 1993</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults 14%</td>
<td>Adults 23%</td>
</tr>
<tr>
<td>Blind &amp; Disabled 39%</td>
<td>Blind &amp; Disabled 15%</td>
</tr>
<tr>
<td>Children 19%</td>
<td>Elderly 12%</td>
</tr>
<tr>
<td>Elderly 28%</td>
<td>Children 50%</td>
</tr>
<tr>
<td>Expenditures = $124.6 Billion</td>
<td>Beneficiaries = 32.3 Million</td>
</tr>
</tbody>
</table>

*Note: Does not include Arizona or US territories*
Nursing homes are the single largest Medicaid expenditure. In 1993, nursing homes and facilities specifically designed for the mentally retarded accounted for nearly 29% of total Medicaid expenditures. Of the $44.2 billion Medicaid spent in 1993 on long term care services, the vast majority, 85%, went towards institutional care. Nursing homes constituted 60% and ICF/MRs, 21%.

Chart 2: Medicaid Expenditures by Type of Service, 1993

Source: The Urban Institute, 1994 and the Kaiser Commission on the Future of Medicaid. Note: Expenditures do not include Arizona, US Territories, accounting adjustments or administrative costs.

On average, states spend 36% of their Medicaid budgets on long term care, with 21 states spending 40% or more on these services. Finally, the per capita cost of care for vulnerable populations is far higher than for other Medicaid beneficiaries in part because of the cost of institutional care and in part because their health care needs are often complex and costly. On a per capita basis, Medicaid spending in 1992 averaged about $1,700 per adult and $1,000 per child. In contrast, spending averages $7,600 per elderly and $7,400 per disabled beneficiary, reflecting the greater health and long-term care needs of these groups.

Medicaid is the primary payer of the $75.2 billion the nation spent on nursing home care in 1993. States, with Federal matching funds, are paying the price of the payment system’s institutional bias. Medicaid and out of pocket expenditures by individuals account for 88% of the total nursing home bill in the United States.
Chart 3: National Nursing Home Expenditures, by Source of Payment, 1993 ($ in billions)

<table>
<thead>
<tr>
<th>Source of spending</th>
<th>Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>$36.3</td>
</tr>
<tr>
<td>Medicare</td>
<td>5.7</td>
</tr>
<tr>
<td>Other Federal</td>
<td>1.0</td>
</tr>
<tr>
<td>Other State and local</td>
<td>2.5</td>
</tr>
<tr>
<td>Out-of-pocket payments</td>
<td>29.6</td>
</tr>
<tr>
<td>Private insurance</td>
<td>0.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>75.2</strong></td>
</tr>
</tbody>
</table>


Estimates show that the number of older people needing long term care is growing dramatically and will nearly double in the next 35 years from 7.1 million today to 13.8 million by 2030. Absent changes in policy, the demand for increased nursing home expenditures will grow.

But it is not just the elderly who demand long term care. Increasing numbers of younger persons with disabilities and chronic illness place greater demands on our systems of care. It is estimated that 40% of persons with AIDS become eligible for Medicaid at some point in the course of their illness. This disparate group of consumers is even more vocal than elders about the need for more choices and alternatives to institutional placement.

Changes in population demographics will not be the only influences on the demand for long term care services. Trends in hospital based care will also impact the need for post-acute care. Advances in technology, the advent of the Prospective Payment System, and increased reliance on managed care have been dramatically reducing the number of inpatient days and therefore, the need for acute care bed capacity. In 1978 the average length of stay for all adults was 7.2 days. In 1992 it had dropped to 6.4 days. For adults over 65, the average length of stay in 1978 was 10.6 days, and in 1993 it had dropped to 8.3 days. Occupancy rates for short-stay hospitals have dropped from 73.8% in 1978 to 62.4% in 1992.

With the decrease in inpatient length of stay, there has been an increased emphasis on outpatient care. Surgical procedures, which ten years ago would have
necessitated a hospital stay of a week, are now being performed on an outpatient basis. Examples of this are the advances in arthroscopic knee surgery and the use of lithotripsy in the treatment of kidney stones. Hospitals have also worked to reduce the overall length of stay for inpatient care, by transferring care to either sub-acute levels or to home care services.

While these delivery system changes have taken place at the hospital level, current Federal policy makes it difficult for states to invest in alternatives to institutionalization and divert funding from nursing homes to other services. Medicaid does allow states to seek waivers from current rules in order to develop home and community based alternatives to nursing homes. Although the growth rate is high, only about 2% of total Medicaid outlays fund Home and Community Based waiver services. The majority of that spending is for people who are mentally retarded or developmentally disabled (see Chart 4). Home care services, including personal care, home health and home and community-based waivers, comprised 15% of Medicaid spending on long-term care in 1993. By state, community care spending varies from 5% to 25%.9

Chart 4: Medicaid Spending and Populations Served Under Home and Community Based Waiver Programs, 1991

With a growing population in need of long term care and the changes in how acute care is delivered, a broader range of service alternatives for care will be needed. The nursing home, or a derivative of the current model, will likely remain a critical component. But in order to develop a broad array of alternatives, states seek more flexibility to design new systems and more flexibility to spend Medicaid dollars on non-institutional settings. The evolution from an institutionally biased system to one with a broader array of more flexible services will not be easy. There are more
than 16,000 nursing facilities with over 1.6 million beds, 94% of which are certified to receive Medicaid. Given that extensive stock of nursing homes now relying on Medicaid payments, efforts to divert those funds will have implications for the financial viability of those facilities and for the quality of care of residents who live in them and rely on them for their well-being.

This paper examines how a state could proceed to move from an institutionally biased system of care to a more community based one and raises issues that must be addressed in order for the transition to be least disruptive to nursing home residents and the owners and staff of those facilities. The primary challenge to states is to develop strategies which overcome the entitlement basis of institutional care.

II. Lessons Learned from Deinstitutionalization of Mental Health Facilities

State activity to move the traditional long term care system away from a reliance on institutions is reminiscent of the movement to deinstitutionalize state mental health institutions. While a direct comparison cannot be made, there may be lessons that inform the restructuring of the long term care system.

The history of mental health policy illustrates how changes in financing arrangements have had dramatic effects on the shape of the mental health system and the flow of patients to different types of institutions in varying historical periods. Although the anti-institutional orientation of the post World War II period set the attitudinal stage for “deinstitutionalization” facilitated by the availability of psychotropic drugs, the creation of federal welfare entitlements (Medicare, Medicaid, Supplemental Security Income, Social Security Disability Insurance) provided the funding mechanisms that ultimately enabled the movement of patients from hospitals to communities, as well as other institutional service settings.

The number of long-term patients at public institutions fell precipitously after 1965, largely because changes in funding patterns led to a sharp decline in elderly and chronic patients. Although many patients were released to communities, the significant transfer, or transinstitutionalization of patients to nursing homes, to some extent, undercut the belief that significant numbers of patients were “deinstitutionalized” to the community. As states move to reduce reliance on nursing homes, careful consideration must be given to what will replace them. Can long term care avoid such “trans-institutionalization”? Will a move away from nursing homes really reduce cost growth of institutions?

Despite a quarter century of reductions in the number of beds in state mental hospitals, 58% of the treatment cost of mental illness continues to finance institutionally based care. Reduction of institutional beds did not necessarily reduce institutional costs. However only about 3% of persons with a recent mental
health disorder have ever been institutionalized for psychiatric treatment. The nation continues to invest far more heavily in the small number of affected individuals who require institutional care than in the much larger number of mentally ill individuals who receive ambulatory care or no care at all. As of 1988, 2/3 of funds from all sources supported institutional care, a proportion considerably higher than in the general health care arena.\textsuperscript{13}

Several factors have influenced the heavy investment in institutional care:

- Maintenance of hospital certification (necessary for reimbursement) has required major capital investment in deteriorating physical plants;
- High overhead and staffing costs to support “treatment environments” which have fewer and fewer patients, but increasingly stiff clinical standards;
- Social pressure for hospitals to perform clinical, as well as social control functions; and
- Political demand to maintain hospitals as community employers.

A. Implications of Transinstitutionalization on State Hospital Identity: Closure and Downsizing

The identity of the state institution changed as the number of long-term aged and chronic patients fell sharply - and mental hospitals began to provide more short and intermediate-term care and treatment for severely mentally ill patients. This shift in patient profile had implications for staff training, recruitment and retention as well as hospital certification, and maintenance of high hospital costs.

State Mental Health Authority (SMHA) Directors often face the competing and conflicting demands to maintain \textbf{AND} downsize or close state hospitals. However, any SMHA Director soon realizes, closing even the most redundant institution unleashes a political onslaught.\textsuperscript{14}

Many states have initiated planning processes to determine the appropriate role and size of the state hospital, as well as its relationship to the total mental health service system. Although some states began their planning process as a “hospital closure” initiative, it seems clear that such discussions have generally not been successful. How the issue is framed is at least as important as the process that is put in place.

The ultimate focus of the plan should be on the hospital’s role, not its size, just as in long term care the discussion must focus on the needs of recipients and what any role nursing homes should play. The hospital is a part of the community, and in a community-based system of care, the hospital is designed like other services, to help people live successfully in the community, not simply to keep them out of the community or keep them in. The emphasis in the plan is on creating services
consistent with the mission of the system, and not simply on eliminating beds.

Hospital down-sizing, which occurs in conjunction with the development of community services, succeeds in an environment which supports inter-related objectives:

- Offer relevant and effective treatment programs.
- Integrate the efforts of hospital and community staff in treating patients.
- Improve the environments within which treatment occurs;
- Down-sizing and/or closure activities should be organized within the context of campus/hospital re-use;

B. Lessons Learned: How to Manage the Process

- The most important lesson learned from the mental health community is that a long-term planning process must be set in the context of the entire system in order to close or downsize facilities. The identity, role and future of the particular facility/institution must be interrelated with discussion of the TOTAL service system.

- Discussions about "bed closures" are not helpful in a system void. "Bed closure" is financially effective when wards or units are closed and closures are tied to cost efficiencies assumed by reducing staff. Furthermore, an alternative to the "bed" must be in place for the client. Given the volatile political response to staff reductions, a staff reallocation plan must be devised. Many states have been successful shifting staff to community programs. However, this may require lengthy personnel discussions regarding union contracts and pay differential between state and private providers. Because the vast majority of nursing homes are privately owned, states will not generally experience such staffing problems in downsizing nursing homes. However, it is not unreasonable to assume that as a nursing home's identity changes, the staff identity must also change, and closing nursing homes will have an economic impact in the community.

- Hospital closures that are tied to legal actions, e.g. consent decrees, may relieve pressures from one facility, but shift it to another (e.g. closures in admissions to mental retardation institutions have precipitated inappropriate admissions to mental health facilities) or blocked needed discharge of persons from one facility to another because beds in the more appropriate facility were closed by consent decree. The reality of facility closure may be artificial if all that is accomplished is switching patients to other institutions. Nevertheless, despite their difficulties, consent decrees have been extremely effective in closing mental health and mental retardation facilities. It is the weight of the
consent decree that keeps beds closed, even when there are other pressures (social, clinical, etc.) to admit patients to hospitals. Yet the movement away from a reliance on nursing homes in state long term care systems has no such consent decree to motivate and support action.

- If a facility is marked for closure or downsizing, a hard-line must be drawn regarding expensive capital improvements. This may conflict with fire and life safety codes necessary for maintaining licensure and/or certification. It is essential that all policy makers, providers and consumers support the decision to close/downsize, or otherwise short-term decision making may be at odds with the long-term process. And during this transition effort, resident safety and care must remain a paramount concern.

III. State Strategies to Reduce the Reliance on Nursing Homes

Unlike state experiences in downsizing institutions for the mentally ill, efforts to reduce reliance on nursing homes are far less developed. Some states have relied heavily on regulatory approaches that control the supply of and access to nursing home beds; others have invested in stimulating the growth of community alternatives. A combination of strategies often is employed.

This paper is not meant to be a comprehensive compendium of all possible downsizing and diversion strategies. Rather, the paper seeks to identify common trends and issues and highlight these for further discussion. In July of 1994, a telephone survey of the states was conducted by the Muskie Institute for Public Affairs at the University of Southern Maine to investigate the strategies used in controlling long term care costs. Regardless of the strategy or approach taken by states, two guiding principles have been at the core of the policy changes:

- Consumers prefer home and community base alternatives;
- The use of and diversion to home and community based services is less costly that institutional care.

The strategies for operationalizing these principles are as diverse and varied as the states themselves. Nevertheless, four key approaches have emerged from state’s efforts to reduce the cost of institutional long term care services.

A. Downsize the overall supply of nursing home beds; develop sub-acute services.
B. Divert individuals from nursing facilities before they are admitted.
C. Convert facilities; expand residential and community options.
D. Improve the overall management and delivery of long term care services from a state and system-wide perspective.
Some of the complex issues and decisions that confront policy makers include:

- What is a reasonable time frame for implementing policy change?
- What quality assurance systems need to be in place (e.g. as facilities are closed, as new home based options are developed)?
- What is the most effective and appropriate mix of regulatory and non-regulatory approaches?
- Given limited available resources, what is the best investment of state funds (e.g. buying back CON beds, increasing case management, expanding state funded programs)?
- What are the legal issues and implications of taking certain actions ("taking of property", receivership, effect on bondholders) and what is the cost to the state (e.g. diversion of personnel to legal proceedings, goodwill, other)?
- How can states work "with" rather than "against" the various vested interests in pursuing these strategies?
- How do states overcome a "chicken and egg" problem, e.g. how do you simultaneously reduce the demand for nursing home beds and stimulate home and community based alternatives?

The following section outlines four major strategies identified above and discusses some of the issues that have arisen in the states in the course of implementing those strategies.

A. Downsizing

Because nursing homes have been the predominant provider of long term care services, many states have focused their efforts on reducing the overall capacity and supply of beds available. Strategies to reduce and/or limit the overall supply of nursing home beds have included 1) the use of moratoria on new bed construction, 2) buying back Certificate of Need (CON) authorization for beds that have been approved but not put in service, 3) "banking" CON beds, 4) reducing capacity as a result of delicensing or receivership proceedings, 5) reimbursement incentives and disincentives, and 6) through encouraging the development of sub-acute care.

A number of states have considered and examined whether it is possible to reduce beds by "revoking a Certificate of Need" or a "reversing" the Certificate of Need process. No state (that we know of) has actually initiated such an action and in fact in Maine, the Attorney General cautioned the legislature that such an action could be considered a "taking of property". In essence, if the government authorizes a facility to take an action and proceed to invest in an enterprise, the government
cannot revoke that authorization without compensating the facility for damages. This is separate and distinct from the issue of delicensing or closing a facility for failure to meet certain quality or licensure standards. States have this authority and many facilities have closed as a result of delicensure proceedings.

In states where tax exempt and non-tax exempt bonds are issued through health and higher education authorities, other issues arise. In Maine, for example, most of the debt that has been issued to finance nursing facilities has been issued with a "moral obligation reserve" of the state. In essence, if a nursing facility (or hospital or educational institution) is unable to pay its debt service, the governor must ask the legislature to make an appropriation to cover those payments and this request must be made for each of the remaining years of the debt service. If the legislature fails to make such an appropriation, then the state's overall bond rating for all bonds that have been issued would be in jeopardy and it is highly likely that the state's bond rating would be reduced. This particular provision is not common in other states, although apparently Connecticut and New York have similar "moral obligation" covenants.

Another feature of bond issuances that is more common throughout the country is the provision that states must agree not to take any action that will inhibit or impair the bondholders' ability to be paid. Furthermore, the bond contracts may include a covenant that the facility must be able to generate revenue sufficient to cover 125% of the debt service. Thus, if a facility wanted to close a wing, for example, it would have to show that it could still cover its debt service through a different mix of revenue streams or patients.

The following section outlines some of the approaches states have used to reduce overall bed capacity.

1. Certificate of Need/Moratoria

A common strategy to limit the growth of nursing home beds is through the CON process and/or through moratoriums and caps on bed construction. A number of states have limited growth in nursing home beds through either a moratorium on nursing home beds or a cap on the total number of nursing facility beds in the state.

Washington state placed a moratorium on new bed construction and established a goal of reducing overall bed supply by 750 (45 beds/1000). The legislature cut $35 million in general fund revenue (biennium) for institutional long term care services and increased support for community based services by $23 million. In addition, facilities that voluntarily took beds out of service could "bank" the beds and continue to claim ownership for those beds. However, if a facility wanted to put those beds back in service, they had to apply for a CON which will be reviewed against the targeted bench mark of 45 beds/1,000 for a particular service area or county.
The State of Maine also established a bed reduction goal of 800 beds and the legislature, like Washington state, decreased funding for nursing facility services and increased the appropriation for home and community based services.

The state of Wisconsin has capped the number of nursing home beds in the state for the last 13 years. Unlike Washington, however, if a bed is delicensed the bed is no longer available to a facility. In fact, for every bed that is delicensed, a Medicaid waiver slot is opened (including ICF-MR beds). For county-run facilities, which operate many of the ICF-MR beds, this can translate into an immediate reduction in the levy on property taxes and the availability of funds for community alternatives. For some facilities that also run meals on wheels programs or home health programs, there is a potential indirect benefit that may accrue if services for Medicaid waiver clients are purchased through the facility owned service. In other instances, a nursing home might not receive any tangible direct benefit from delicensing beds but may benefit from community good will.

Other states have modified their CON programs to close the loophole that allowed facilities to add 5-10 beds and/or a certain percentage of beds without CON approval. For many states operating CON programs, this loophole contributed significantly to the "creep" upward in the nursing home bed supply.

The growth of nursing home beds has also been limited by tying the approval of new beds to the legislative appropriation process. In other words, in some states no new Medicaid funded nursing facility beds can be approved without an explicit appropriation for the beds from the legislature. In Washington state, the legislature has also placed a limit on the rate of growth of nursing home expenditures.

2. Buy-Back of Beds

For at least one state, limiting the growth of new beds through a moratorium or bed cap was complemented by a more aggressive strategy to prevent previously approved beds from coming on line. In Connecticut, the legislature found "evidence of insufficient need for all the nursing home beds approved . . . and not yet constructed" and found that allowing unnecessary beds and facilities to be built would result "in severely damaging economic consequences to the state and to consumers". The legislature appropriated $10 million to "buy back" beds that were "in the pipeline", i.e., beds that had been approved but were not yet constructed. The CON of any facility that had not yet spent 25% of the cost of its approved CON was required to turnover its CON approval and the state compensated the owner for the audited costs of the proposal to date. Project costs include the capital.
costs approved in the CON exclusive of land acquisition costs.

Facilities that had spent more than 25% of their CON approval but had not yet put beds into service were given the option of the buy-back program. Facilities that had initiated the addition or 10 or fewer beds, and had spent 25% of project costs could apply for authorization to proceed with the completion of the beds. Other facilities that had initiated the addition of 10 or fewer beds could apply for compensation.

The legislation included provisions for hearings and other appeal processes for disputes in the calculation of compensation amounts. Although Connecticut is the only identified state that has actually "bought back" beds, other states are struggling with similar issues regarding the conversion of nursing facility level beds to assisted living facilities. In other states, officials are examining the cost effectiveness of buying down existing mortgages of nursing facilities to provide stimulus and financial support for development/conversion of beds to assisted living.

3. "Banking Beds"

Washington state provided incentives for facilities to "bank" their CON approved beds. Through its reimbursement system, facilities are paid a rate that presumes an 85% occupancy rate. If a facility's occupancy falls below 85%, it has an incentive to delicense its beds and "bank" those beds for potential use at a later time or in another area of the state.

4. Delicensing/Closing

For some states, delicensing of poor quality facilities is another approach that reduces bed capacity although it may not be part on an overall bed reduction strategy. Depending on the number and mix of residents in a facility, some residents may be transferred to another facility; others may be placed in a community setting. In Oregon, the state has broad authority to assess fines if care is not adequate and to restrict admissions to nursing facilities by both public and private patients until deficiencies are corrected.

The success that states have had in delicensing poor quality facilities is in some instances a function of the size of the facility and the amount of capital the facility has to challenge a delicensing action or take the corrective steps necessary to come into compliance. Larger nursing facilities with large investments in a facility are usually more willing and able to challenge a delicensing action whereas smaller facilities and adult foster homes may be more apt to close without a prolonged legal challenge.

In general, state officials did not view delicensing as a pro-active strategy to address the problem of over-bedding or reduce the overall cost of
institutional care. Notably, in developing a system of services, care must be given to assuring geographic accessibility to care. Closing beds should be done with that concern for access in mind. But decisions to close beds which are providing poor quality of care must be done, regardless of access concerns if one holds quality of care to be paramount.

In Wisconsin, the state has a contingency fund set aside if a facility goes into receivership and a contract with a management company to manage a facility during the receivership process. Managing the closure of a facility and transferring residents to other settings requires a major investment of energy and resources of state personnel even with the availability of a management contract to do so.

5. Reimbursement

The reimbursement structure of Medicaid payment systems for nursing facility services can also provide incentives to either reduce Medicaid occupancy and/or to shift the number and mix of Medicaid residents being served.

*Occupancy Provisions* As indicated previously, a number of states include an occupancy provision that presumes a minimum occupancy level. These provisions can provide an incentive for a facility to delicense a certain number of beds in order to maintain an occupancy level at a minimum threshold. In Wisconsin, the state has also included a provision to “hold beds”. The nursing home is paid 85% of its rate for up to two weeks of a bed held provided the facility has an overall occupancy of 95% or more. While a number of states include such provision in their reimbursement systems, they are generally viewed as providing a relatively weak incentive or disincentive to delicense beds. In fact, for some, such a provision could provide an incentive to keep a high occupancy level rather than discharge residents in a timely manner.

Some states have also included provisions to protect some of the fixed costs of a facility that is closing or downsizing. Under these provisions, states may negotiate to pay a rate that covers certain administrative and staffing costs during a transition period to allow an orderly downsizing and/or closing of a facility.

*Case Mix Reimbursement* A number of states are also pursuing and implementing case mix payment systems for nursing facilities. Under a case mix system, facilities are paid a higher rate for residents with heavier care needs and a lower rate for residents with lower care needs. Such a system provides a way to more rationally allocate resources to facilities. It also provides strong incentives for facilities to accept the heavier care residents and not to accept and/or to discharge lighter care residents. Many states that
have implemented case mix systems have experienced an overall increase in
the case mix of the nursing facilities in the state. Anecdotal evidence suggests
that the lighter care residents are not being admitted and/or becoming backed
up in hospitals. As states experience an increase in nursing facility case mix,
it will be important to monitor whether more of the residents are being paid
for by Medicare (as skilled) and whether fewer Medicaid clients are being
admitted.

Industry representatives in Oregon and Washington stressed the importance
of differentiating payment based on the conditions of the resident. A
provider representative in Wisconsin noted that nursing home residents
today are more impaired and require a higher level of skilled care than may
have been true 5-10 years ago when Wisconsin’s Community Options
Program was initiated. With the increased availability and use of community
based alternatives, the mix and acuity of nursing facility residents has
increased. From his perspective, the community options program, originally
designed as an alternative to nursing facility services, in fact now serves a
very different population.

Other industry representatives expressed a similar view and stressed the
importance of designing reimbursement systems that keep pace with the
changing needs and mix of the residents.

6. Developing Sub-Acute Care

The following section on the development of sub-acute care services describes
some of the strategies that have emerged in the private sector as opposed to
strategies implemented by the states. It describes some of the industry factors
that are causing hospitals and nursing facilities to investigate alternative
methods of providing services.

Trends in hospital length of stay and increasing outpatient care have led to
the development of a treatment setting that is in between acute hospital and
nursing facility care. Sub-acute care may take multiple forms and includes
post-acute care which is delivered to people in Medicare certified skilled
nursing units, step-down units located in hospitals and rehabilitation
facilities, as well as through the provision of “high tech” home care services
delivered to people living in their own homes. The care which is provided
also varies significantly in length of time delivered. For example, a person
may require a short recuperative care stay of two weeks or less in a skilled
nursing unit following an acute stay, be discharged to his or her home and
then receive intensive home care services. Other people, as a result of a
medically complicated chronic illness, may receive the sub-acute services in
either an institutional or home care setting for years.

These trends have resulted in hospitals re-configuring their services and
physical plants to respond to the new marketplace needs. Many hospitals have converted inpatient beds to outpatient areas, and created strong alliances with home care and other services. They have also developed an increased reliance on sub-acute services. The definition of sub-acute differs depending on the orientation of the entity defining the service. The only level of agreement which may be found is that the care which is delivered is less intensive than that which would be provided in the acute care setting. Many states are experiencing shifts in Medicare payment for a higher proportion of post acute care stays than in the past.

A specific area of development in New England has been hospital based skilled nursing units. These units are more prevalent in other parts of the country. Hospital based skilled nursing units are typically small units, located within a hospital, which focus on short stay, post acute recuperative and rehabilitative care. In a recent study by the American Hospital Association, hospital based skilled nursing units were described as having the following characteristics: an average bed size of 23 beds; an average length of stay of 19 days; 89.9% are created through the conversion of acute care hospital beds; the majority of patients are discharged to home; five or more hours of nursing care per patient per day are provided; and 84% of the care is paid for by Medicare. Many of these units admit seven days a week, on all three shifts and provide therapy services at least five, if not seven, days per week. By offering highly skilled nursing care and rehabilitation services, these units have been an effective response to marketplace pressures and have reduced hospitals' overall lengths of stay.

Financially, there are major differences in payment sources for these services. Because Medicare covers 100 days of post acute skilled nursing care for each spell of illness, Medicare is generally the primary payor of short-stay recuperative care. During the first three years of operation, hospital based and facility based skilled nursing units are reimbursed by Medicare under a cost based reimbursement system as a new provider and are not subject to routine costs limits. For the hospital based provider, the sponsoring hospital is permitted to allocate hospital overhead costs on to the unit. These costs based reimbursement approaches and the capacity to allocate some overhead subsequently results in initial rates of approximately $500 per day. Conversely, Medicaid rates, even for new facilities, are typically tied to case mix categories and are subject to reimbursement ceilings, thereby resulting in rates which may be hundreds of dollars less than the Medicare rate. Therefore Medicaid is not considered a desirable payment source. Managed care is most typically a percentage discount from the Medicare rate unless the provider is involved in a full risk or capitated payment sources and then the reimbursement may be tied to a capitated rate, based on diagnosis.

Hospitals and other providers are forming alliances or directly developing a network of sub-acute services which include off-site (from the hospital)
skilled nursing units and home care services capable of providing highly skilled care, including home infusion therapy and rehabilitation services. The presence of managed care, particularly for the Medicare eligible population, is a major force in the development of these services. The managed care or Medicare risk products remove the three day prior hospitalization requirement for patients receiving care in a skilled nursing unit. Many managed care providers are exploring direct admissions to these units. Examples of conditions for which sub-acute services are thought to have the capacity to provide appropriate care without the need for an acute care stay are uncomplicated pneumonia, dehydration, and certain cancer treatments, including chemotherapy.

Nursing homes have also responded to increased pressure from both payers, particularly Medicaid, and from hospitals anxious to discharge older patients more quickly. Nursing homes have scaled their services to a higher level of care, essentially increasing the demand for community based and other alternatives to nursing homes, which is consistent with the homes receiving Medicaid payment through a case mix reimbursement system focused on higher acuity levels. Many of the facilities are also initiating sub-acute units which offer more highly skilled and rehabilitative care. In Massachusetts, where the development of these units is burgeoning, the units provide approximately 3.5 to 5 hours of nursing care per day, skilled care for those who experience lengths of stay between 30-90 days, as well as care to the long staying population of older adults. Increasingly more of the residents are discharged to home or to a less intensive level of care.

Nursing homes have made significant physical plant changes in order to accommodate this new type of patient/resident including creating large rehabilitation and occupational therapy areas and separate entrances for the units. Managed care providers, particularly those Medicare Managed Risk Contract providers, are developing relationships with nursing homes to provide short stay recuperative care to their enrollees. Nursing homes and hospitals have collaborated to develop sub-acute services. In these instance the nursing home provides space, support and skilled nursing care and the hospital may contribute technically trained staff to oversee “high tech” services including intravenous (IV) therapy or rehabilitative care.

*Development Approaches* For the most part, sub-acute units are developed either through the conversion of beds or the addition of beds under some form of a Certificate of Need process or by refocusing existing long term care bed capacity. To date, there has been no regulatory distinction between sub-acute services and skilled nursing services certified by Medicare, nor is there any distinction in units which focus on a short stay, recuperative population versus those which care for people who will remain for years. Both the JCAHO and HCFA are preparing new guidelines for sub-acute services due out in late 1994 or early 1995. Without clear distinctions,
confusion among providers as well as payers and consumers may result in purchasing care which is inappropriate for the care needs of the individual. For instance, two providers may be “marketing” sub-acute services, one with the capacity to provide 3 hours of nursing care per day and one to two hours of therapy five days per week, while the other, has clinical capacity and expertise to provide up to six hours of care per day, provides IV therapy and has therapy of all types available daily. Depending on the needs of the patient, those who have highly skilled nursing care needs, including the use of “high tech” equipment and want an aggressive rehabilitation schedule will not be appropriately served by the first provider. Additionally, for the older adult consumer who needs a long stay nursing home placement and who requires daily assistance with activities of daily living but not highly skilled nursing care, they may experience difficulty in obtaining the placement because the existing facilities in the area are focusing on the sub-acute population.

From the provider’s perspective, the short stay units are being required to comply with requirements which were designed for the long stay resident in mind, including the full scale resident assessment, required by HCFA to be conducted within fourteen days of the admission of a new resident, even for those patients who may only stay two weeks and then go home. Furthermore, the bed planning formulas generally utilized by states to calculate the number of needed nursing home beds will not accurately capture the demand for this type of care. Hospitals are experiencing increasing shifts in the types of patients being transferred to nursing homes, some with more than half being transferred for short stay recuperative care, in stark contrast to the experience even three to five years ago.

Future Outlook  Overall, these trends are expected to continue for the foreseeable future and demand will increase as the percentage of the population, including older adults, enrolled in managed care increases. The lines dividing the care which is provided are becoming increasingly blurred with the advances in technology and the increased capacity of sub-acute care providers to offer services which act as a substitute or alternative to acute care. A recent study commissioned by the American Health Care Association identified 62 specific DRGs for which sub-acute care facilities could provide appropriate care and would enable a substantial savings to Medicare by reducing the overall length of stay sufficiently to have an impact on the DRG payment and the overall length of stay. Included in these are digestive system procedures, skin graft and wound debridement, kidney track infections, some cancer care and respiratory disorders. Within the same study, five (5) DRGs were identified for which sub-acute care could substitute entirely for an acute care stay.16 Included in these five were medical back problems, skin ulcers and osteomyelitis. These trends will create the need for more home based as well as residential alternatives to nursing homes which are now focusing on skilled nursing care. The challenge for states lies in
promoting the development of these options, while at the same time, attempting to control expenditures. This balancing act creates the need for significant expertise in multiple areas and flexibility in planning for both recuperative care and chronic care for a highly diverse older and disabled population.

B. Diversion

Another strategy for reducing institutional Medicaid costs is to divert people from nursing facilities before they are admitted. Some states have invested heavily in such strategies and have only used some of the more regulatory approaches discussed above as a complement to diversion programs and programs that build an infrastructure for home and community based programs. Some of the diversion strategies that states have used include:

1. Case Management

States have used a variety of approaches to strengthen their case management systems to support and divert people to community based options. Many of these systems have been widely studied and are discussed in the literature at much greater length and depth than available for this paper. Generally, case management is defined to include applicant assessment, service planning, service authorization, service arranging, service/consumer monitoring and periodic reassessment.

At the state level, the way in which such services are administered varies greatly. Some states use a "consolidated" approach where all long term care responsibilities—institutional and home and community based care—are brought together in one state agency. Another model is a coordinated model with various agencies sharing responsibility for components of the system. In another model, various agencies are responsible for their own long term care programs. Case management functions are typically performed by organizations which do not provide direct services to avoid financial incentives to over-authorize services which may not be the most appropriate and cost effective. Area Agencies on Aging (AAAs), county health or social service agencies and other non-profit organizations are typically designated to perform case management functions.

All of the state officials that were interviewed stressed the importance of a strong case management function as a key component of shifting the locus of care from institutional settings to home and community settings. The following examples are a few of the ways that some of the states have sought to enhance and/or expand the case management function.

Case Managers for Nursing Homes  In Washington state, state employees in regional offices are assigned as case managers for nursing facilities in an area.
The case managers are responsible for identifying the discharge potential of residents in the area nursing facilities and for facilitating discharge planning for those individuals.

Risk Intervention Program  Oregon has developed a Risk Intervention Program that identifies individuals in the community who are deteriorating or at risk of institutional placement. Case workers are employed by the state or AAAs to work with neighbors, volunteers and other community organizations and services to reduce the premature institutionalization of such individuals.

Preadmission Screening/Community Options Programs  A number of states have implemented preadmission screening and assessment programs for both Medicaid and private pay individuals seeking admission to a nursing facility. A key component of such programs often includes the development and presentation of community alternatives and their cost to potential nursing facility applicants.

Wisconsin developed a preadmission screening program that was to be implemented on a phase-in basis by county. The Wisconsin legislature made it a class C violation for a nursing facility to admit a potential Medicaid eligible client if the person had not first had the Community Options Program presented to them. The law was implemented on a county by county basis and was only implemented if there were sufficient funds in the county to assess everyone who applied. The law has never been implemented on a state wide basis and has been subject to the political and economic environment of each county.

In 1993, the Maine legislature made a number of changes to its preadmission and assessment procedures. Any Medicaid eligible client who is assessed in need of nursing facility care must also be assessed to determine whether home or other community based alternatives are available, appropriate and cost effective. The applicant must be provided with a proposed plan of care and with an explanation of the relative costliness of the available options. A care plan and case management services must be offered to low income applicants on a sliding scale basis if the person chooses a home or community based alternative. Private pay individuals are being offered a similar program on a demonstration basis in three areas of the state.

Single Point of Entry Case Management Systems  A number of states are firmly committed to the need for and importance of "one stop shopping" for services for the elderly. In Indiana, case management for all Indiana long term care services is provided through the state's 16 Area Agencies on Aging. Indiana's long term care case managers screen applicants, assess and reassess eligible persons, develop and authorize service plans, arrange services and monitor the service delivery. Non-profit Home Care Corporations (primarily
AAAs) in Massachusetts assess the needs of seniors and find placement options regardless of payment source. Other single point of entry systems have been implemented in Colorado, Connecticut, Illinois, Maine, Ohio, Oregon, Pennsylvania, North Dakota, South Dakota and Wisconsin.

2. Reimbursement Incentives

The development of case mix reimbursement systems for nursing facilities has increased interest in the application and use of similar concepts in other settings such as board and care homes, assisted living facilities and home and community based settings. Oregon and Washington both expressed an interest in moving toward a system wide case mix system where rates are determined on the basis of the needs of the resident and the resources required to meet those needs rather on the basis of categorical rates for types of services.

3. Medical Eligibility Criteria

Some states have tightened their medical eligibility criteria as a way to control Medicaid expenditures for long term care services and to divert people to home and community based services. Tightening nursing facility eligibility criteria, however, also has the effect of tightening the criteria for individuals who are being served by Medicaid Home and Community Based Services waiver programs. Participants failing to meet nursing home level of care criteria would also fail to qualify for continued home and community services under Medicaid waivers. This may result in the expenditure of additional state funds for expanded home based care programs for which there may be no federal match or the use of other funding sources from other Medicaid programs (such as home health services and private duty nursing).

4. Nurse Practice Act

Representatives in Oregon identified the expansion of the Nurse Practice Act as one of the most important policy changes for increasing access to and the availability of home and community based services. The change in the law allows nurses to delegate nursing functions to another person if the nurse is convinced that the non-nurse can appropriately perform the function. This has expanded the number and types of services that can be performed in the home and has great potential for cost savings.

C. Expansion of the Availability of Residential and Community Options

Most states expressed the strong view that the expansion of funding for and availability of community based services is a fundamental component of any strategy to reduce the cost of institutional long term care services. This commitment was expressed in a variety of forms.
1. **State Models to Expand Residential and Community Options**

Demographic trends suggest that the need for long term care will increase in the future. Oregon has addressed future needs by expanding family care, assisted living and home and community based services. In 1981 the state served about 8,000 Medicaid recipients in nursing facilities. By December 1993, the number had dropped to 7,500. Meanwhile, the number of people served in the community grew from about 8,000 in 1981 to 17,700 by the end of 1993. In the absence of community expansion, the state would have spent an additional $720 million if it had relied on institutional services to meet growing needs. One study concluded that Oregon’s use of home and community based services instead of nursing facility care had saved an estimated $227 million between 1981 and 1991 out of projected direct service expenditure of $1.35 billion for the period.

The average cost per month for a person in the community has risen 50%, from $300 in 1985 to $450 in 1993. By comparison, the cost for a Medicaid recipient in a nursing home has risen over 100% from $850 in 1995 to $1750 at the end of 1993.

Oregon invested heavily in promoting the growth of adult foster homes as an alternative to institutional care. This commitment included recruiting adult foster homes for participation in the program, training staff and changing licensure requirements for small homes and encouraging family members to run adult foster homes. In addition, adult foster homes were not subject to the provisions of the CON law.

The state of Washington's experience shows how a balanced strategy can affect spending growth. Washington saw its Medicaid nursing home expenditures rise from $290 million in the 1981-1983 biennium, to $922 million (218%) in 1993-1995 while the Medicaid nursing home caseload remained relatively stable. The caseload grew from 15,600 in 1981 to 17,200 in 1989. It has remained stable and has begun to decline over the last two years. Medicaid rates to nursing facilities in Washington rose from $50.45 a day in FY 1988 to $92.95 in FY 1993.

Community care spending in Washington has grown from $50 million in 1981 to just under $300 million in 1993. The community care caseload has risen from 11,000 people in 1981 to 24,000 in 1993. An analysis of the profiles of community and nursing home residents shows that both populations have similar levels of ADL impairments. State officials set a specific policy to reduce nursing home supply to 45 beds per thousand from its present level of 50.6 per thousand through the expansion of assisted living and community services. Interestingly, the expansion has been generated in Medicaid waiver (federally reimbursed) programs rather than state general revenue programs.
In the 1993-1995 budget, the legislature directed the Aging and Adult Services Division to reduce supply by 750 beds over a two year period. Within eight months, 692 beds have been removed.

A balance between institutional and community based services will not be achieved in the near term. Oregon's experience suggests that steady growth and careful planning are needed to develop the infrastructure and capacity to provide new services. In addition, changes in the ways in which services are delivered, especially the nurse practice act, and a mechanism to allocate services are needed.

Wisconsin developed a community options program that included a comprehensive assessment, care planning and expanded home and community based services for those not eligible for Medicaid waiver services. Wisconsin particularly emphasized in-home services to alternative living situations in comparison to Oregon and Washington. Studies conducted in Wisconsin indicate that the net savings in per-person public expenditures associated with home and community-based care amounted to about 16%, compared with the cost of institutional care.

While expanding the number of beneficiaries using home and community-based care, these three states were able to control the number of nursing facility beds. Between 1982 and 1992, the number of licensed nursing facility beds increased 20.5% nationally, while the combined number of beds in Oregon, Washington and Wisconsin declined 1.3%.

2. The Assisted Living Model to Expand Residential and Community Options

As states have developed strategies to expand the supply of service options, they have recognized that first and foremost nursing homes provide housing for residents. In fact in some states, particularly in rural areas, a significant percentage of nursing home residents have very few ADL impairments. There are a number of housing models that serve as a long term care setting. The most extensive is board and care homes which typically serve people who do not require the level of care in a nursing home. More recently, as people in board and care "age-in-place," mutually exclusive level of care criteria are being dropped. Personal care and intermittent skilled care are being provided in board and care models. Home health and skilled nursing services are often provided by an outside agency and the costs are usually not included in the rate paid to the board and care home.

What is assisted living? Assisted living is emerging as a model which serves people who qualify for nursing home care but require primarily supportive rather than skilled medical services. This model also emphasizes resident autonomy, residential units with living, eating (kitchenette or
cooking capacity) and sleeping areas and an attached bath. Board and care models usually require shared bedrooms, common baths and congregate dining. Assisted living highlights the housing component of long term care. All residents in assisted living require services and most states require that low income residents must meet the nursing home level of care criteria in order to receive state subsidies (a requirement of the 2176 waiver programs). Services are provided by assisted living staff and the costs are included in the rate. States make payments from SSI to cover board and care costs and Medicaid waiver funds to pay for services.

Supportive housing is a third model in which supportive services are provided by outside agencies to people in conventional elderly housing. While the percentage varies, usually most residents are independent and do not require services. In this model, services are provided by outside agencies and are funded by Medicaid waiver programs, state general revenue programs, the Older Americans Act or other sources and are not covered in the rental payment.

Assisted living has multiple meanings throughout the country. In many states, assisted living is synonymous with board and care. Keren Brown Wilson, President of Concepts in Community Care in Portland, Oregon has developed a matrix that compares the various models along three dimensions: autonomy, environment and service capacity (see Table 1). Leading states have intentionally defined assisted living as a more residential and home-like model than nursing facilities in an attempt to avoid creating institutional living under another term. Using this approach, Oregon, Massachusetts, Ohio and Washington require single occupancy units with living, sleeping and eating areas, an attached bath, either a kitchenette of cooking capacity in the unit and a lockable door.

<table>
<thead>
<tr>
<th>Housing with services</th>
<th>Autonomy</th>
<th>Environment</th>
<th>Service Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Most residents are independent.</td>
<td>Apartments with a higher square footage than other options.</td>
<td>Use outside providers to deliver service to individual residents.</td>
</tr>
<tr>
<td>Assisted housing</td>
<td>Some residents are independent, others need services.</td>
<td>Residential with smaller units. Includes sleeping, living and eating area with attached bath, cooking capacity and lockable door.</td>
<td>Housekeeping and meals provided; personal care and skilled nursing available from outside providers.</td>
</tr>
<tr>
<td>Nursing home equivalent(1)</td>
<td>Services or supervision needed by all residents. Varies with each resident but maximum choice and decision making is encouraged.</td>
<td>Same as above.</td>
<td>Higher staff service capacity. Provider staff deliver personal care and skilled nursing.</td>
</tr>
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</table>

(1) Most of the residents in this assisted living model would meet the criteria to qualify for placement in a nursing home.
Who can be served? Several states as a matter of public policy provide Medicaid waiver services to people in assisted living who as a condition of eligibility, meet the criteria for nursing home placement. To use the Medicaid waiver, assisted living residents would have to meet the nursing home level of care criteria in order to be eligible for services. Several states do not allow people who require 24 hour skilled care or supervision to be served in assisted living. This may be due to the notion that assisted living could become the next nursing home. However, since states already provide services through HCBS waivers to people in their own homes who have the nursing home level of need, why couldn’t do the same for their assisted living residents? With the focus of assisted living on the home-like setting, providing nursing care services to them in their apartments should not be different from providing them in houses.

Financing In developing a sound housing and service policy, states have not maximized the use of SSI, Medicaid HCBS waivers and Medicaid optional eligibility categories. States respond that raising the SSI standard with 100% state funds to cover the room and board payment raises net state costs. On the contrary, it can reduce net state costs, which must be calculated for the combined cost of SSI and Medicaid.

Examples Using a federal SSI benefit of $434 for a state with a 50% federal matching rate and an average nursing facility rate of $100 a day, the state can raise the SSI payment to $868 a month and make a service payment of $1000 a month for a net state cost of $934. This allows a payment to the assisted living facility of about $1800 (allowing for a $68 personal needs allowance). The net state cost in the nursing home would be $1500 a month, less 50% of the patient paid amount.

A state with a 60% federal match and a Medicaid nursing home rate of $60 a day has a net state cost of $720 a month (30 day month) in a nursing facility. If the state created a special SSI assisted living category with a benefit standard of $650 a month and a service payment of $1000 a month, the net state cost would be $616 a month, for a savings of $104 a month.

These approaches provide a means for states to afford assisted living in many existing market rate facilities for Medicaid recipients. States can also use optional eligibility categories to make assisted living affordable to people with incomes above Medicaid levels who would become recipients if they entered a nursing home.

How can you build supply? There are a number of federal and state resources that can be used to finance the bricks and mortar costs (industrial development bonds, HUD's mortgage insurance, HUD 202 and other programs). The more difficult task for policy makers is measuring the economic impact on nursing homes, who are often a major employer in a
state, especially in rural areas, and the political impact that nursing home owners have on public policy. Many nursing homes are measuring consumer and public policy trends and taking steps to diversify by opening their own assisted living facility or converting all or a portion of their facility to assisted living.

Converting nursing homes to assisted living raises some special challenges for administrators and policy makers. How can policy makers be sure that life in a wing of a building is measurably different from the nursing home section? Can staff be trained to value safety in the nursing home section and resident autonomy, independence and decision making in the assisted living section? Can the building design be modified to accommodate the residential design of assisted living? Finally, how are residents served while a facility is being converted? While conversion may offer a practical strategy to the economic and political implications of assisted living on nursing homes, policy makers need to consider these implications in view of their philosophy and strategy for developing more service options for consumers.

Taking a broader view, states need to link long term care service planning with sources of funds for the construction and rehabilitation of housing for elders and people with disabilities. Discussions among Medicaid, Aging, and Housing Finance agencies are needed to develop policies that provide appropriate housing and services for populations needing long term care. In many states, particularly rural areas, the absence of appropriate housing is a primary reason that many people seek admission to a nursing home. Federal policy also needs to be revised to make it easier to build and operate housing which addresses long term care needs.

D. System Wide Management and Delivery of Long Term Care Services

Responsibility for the financing and delivery of long term care services often rests with a number of different state agencies. One of the most challenging issues for states is how to best organize and manage services for the elderly and people with disabilities within the state administrative framework. A discussion of the administrative and bureaucratic possibilities for organizing state services is beyond the scope of this paper. Nevertheless a few themes emerged as important components of strategies to reduce the cost of institutional long term care services.

- First, it is important to develop a system approach to change. Closing beds without a carefully developed plan to transition consumers and build alternatives will likely yield disaster.

- Second, to achieve a successful plan, a management information system that can provide accurate, timely and comprehensive assessment and financial information on consumers will be required. Ideally such a management information system would provide comparable information on people being
served in the community and people being served in institutional settings.

- Third, a number of states identified the need and interest in financing and delivering long term care services in a managed care context and in a way that coordinates the financing of both the Medicaid and Medicare programs.

When services are organized, delivered and financed as part of a comprehensive managed care program, it is possible to allocate resources more appropriately, control costs and provide services to those in need. There are a few model programs and studies being conducted to address the effectiveness of an integrated model. Please contact the Academy for further details.

IV. Summary

States have pursued a variety of regulatory and non-regulatory strategies to reduce the cost of long term institutional care. No one strategy emerges as a prescription for all states, yet many common themes and approaches are apparent. Making any change that impacts the nursing home industry will lead to significant political battles. States that choose to regulate to supply of beds through imposing regulations on the nursing home industry will be met with opposition not only from the industry, but also local communities that depend on the nursing home for employment and service. States attempting to divert people from the institution must ensure that sufficient services are available to meet the needs of consumers in the community, while at the same time funds still may be tied up in nursing facility care. And states encouraging the development of assisted living as a means of providing housing need to be wary of how it will differ from nursing facility care if it is provided within nursing facility walls.

As the number of people over 65 increases and the needs of younger people who are disabled and ill grows, the need to refine and refocus strategies for the delivery and financing of long term care services will continue to be a major issue for state health policy makers. Finally, since Medicaid represents such a large portion of total state spending, any serious effort to restrain state budgets will impact upon Medicaid. Because 67% of Medicaid expenditures are on the populations using long term care, budgetary forces to reform long term care will be needed. But those forces must be balanced with carefully constructed policy debate about what reforms best meet the needs of the elderly, people with disabilities, and their families.
Endnotes


3. The Urban Institute, 1994.


14. Mechanic, D. and Surles, R. Challenges in State Mental Health Policy


Appendix

Three States with Comprehensive Long Term Care Services: Washington, Oregon, and Wisconsin

These materials were presented at the preconference meeting, The Cost of Institutional Care: How to Get Around the Roadblock to Medicaid Reform, at the National Academy for State Health Policy annual conference, Health Reform Under Construction: States at Work, August 14, 1994, Burlington, Vermont.
WASHINGTON STATE

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND ADULT SERVICES ADMINISTRATION

"LONG-TERM CARE ISSUES"

♦ Rapidly increasing population in need of Long-Term Care services creates more demand on publicly funded services.

♦ A good Long-Term Care system must provide options for Long-Term Care services within available funds.

♦ The Long-Term Care system continues to be biased toward institutional placements.

♦ The community side of the Long-Term Care system serves severe disability, is preferred by most consumers, and is significantly under-funded.

♦ Without disciplined management, the nursing home or institutional budget will consume discretionary resources necessary to finance cost-effective expansion of home/community care. Case Management is essential.
WASHINGTON STATE

Long-Term Care Budget Trends
Nursing Facilities

(Dollars in Millions)

$1,000
$900
$800
$700
$600
$500
$400
$300
$200

(Biennia)

$290  $317  $390  $514  $668  $819  $922

Estimated

Medicaid Caseload
In Nursing Homes

(Clients in Thousands)

20

15.6  15.6  16.1  16.7  17.2  17.4  17.3

0  5  10  15  20

(Biennia)

Estimated
WASHINGTON STATE

PROFILE OF CLIENT PROBLEMS

BY SERVICE TYPE

Nursing Facility
(N=257)

COPES In-Home
(N=125)

ADL Scores
(Max. = 10)

Treatments
(Max. = 13)

(Max. = 15)

8

4.2

2.8

7.4

3.5

1.3

Source: 1,770 Comprehensive Assessments (Oct. 1991)
<table>
<thead>
<tr>
<th>State</th>
<th>Population 65+ (000's)</th>
<th>NH Beds Per 1,000 65+</th>
</tr>
</thead>
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<td>523</td>
<td>41.8</td>
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<tr>
<td>ALASKA</td>
<td>22</td>
<td>38.4</td>
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<tr>
<td>ARIZONA</td>
<td>479</td>
<td>30.4</td>
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<tr>
<td>ARKANSAS</td>
<td>350</td>
<td>72.4</td>
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<tr>
<td>* CALIFORNIA</td>
<td>3,136</td>
<td>40.2</td>
</tr>
<tr>
<td>* COLORADO</td>
<td>329</td>
<td>59.8</td>
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<td>446</td>
<td>62.2</td>
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<td>81</td>
<td>52.7</td>
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<td>FLORIDA</td>
<td>2,369</td>
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<tr>
<td>HAWAII</td>
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<tr>
<td>* IDAHO</td>
<td>121</td>
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<tr>
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<td>* NEW MEXICO</td>
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<td>NEW YORK</td>
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<td>804</td>
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<tr>
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<td>91</td>
<td>80.8</td>
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<tr>
<td>OHIO</td>
<td>1,407</td>
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<tr>
<td>OKLAHOMA</td>
<td>424</td>
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<tr>
<td>* OREGON</td>
<td>391</td>
<td>40.8</td>
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<tr>
<td>PENNSYLVANIA</td>
<td>1,829</td>
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<td>RHODE ISLAND</td>
<td>151</td>
<td>64.9</td>
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<td>SOUTH CAROLINA</td>
<td>397</td>
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<td>102</td>
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<tr>
<td>TEXAS</td>
<td>1,717</td>
<td>64.0</td>
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<tr>
<td>* UTAH</td>
<td>150</td>
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<tr>
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<td>66</td>
<td>53.3</td>
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</tr>
<tr>
<td>WISCONSIN</td>
<td>651</td>
<td>76.1</td>
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<tr>
<td>* WYOMING</td>
<td>47</td>
<td>68.1</td>
</tr>
</tbody>
</table>

(1) 1990 Census Data.
(2) 1991 NH Beds Per 1,000 Elderly Age 65 and Older.

* Other Western States

WASHINGTON ranks:
18th in 65+ Population
30th in NH Beds per 1,000 65+
The Senior and Disabled Services Division

Guiding Principles

Mission Statement:

"To serve older Oregonians and disabled individuals through programs that encourage independence, dignity, and quality of life."

Legislative Mandate (ORS 410):

"... a growing elderly population demands services be provided in a coordinated manner ...; that the elderly and disabled citizens of Oregon will receive the necessary care and services at the least cost and in the least confining situation ... it is appropriate that savings in nursing home ... allocations ... be reallocated to alternative care services..."
NURSING FACILITY & COMMUNITY CASELOADS

Persons Served Per Month (Thousands)

1/75 1/78 1/81 1/84 1/87 1/90 1/93

(Source: SDSDExpenditure Reports)
## Oregon LTC System Data by Service Site

<table>
<thead>
<tr>
<th>Service Site</th>
<th>FTEs/Month</th>
<th>Monthly Cost/FTE</th>
<th>% Public Pay</th>
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</thead>
<tbody>
<tr>
<td>Nursing Homes</td>
<td>7,497</td>
<td>$1,836</td>
<td>56%</td>
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<tr>
<td>Adult Foster Homes</td>
<td>4,883</td>
<td>$536</td>
<td>33%</td>
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<tr>
<td>Assisted Living</td>
<td>418</td>
<td>$1,031</td>
<td>35%</td>
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<tr>
<td>Residential Care</td>
<td>1,202</td>
<td>$529</td>
<td>25%</td>
</tr>
<tr>
<td>Home Care</td>
<td>9,642</td>
<td>$388</td>
<td>?</td>
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<tr>
<td><strong>Total:</strong></td>
<td><strong>23,624</strong></td>
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</table>
TOTAL LONG-TERM CARE COSTS
ACTUAL VS PROJECTED BASED ON '79 LEVELS

CUMULATIVE SAVINGS PER BIENNium

<table>
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<th>Biennium</th>
<th>Savings</th>
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<td>1981-83</td>
<td>($2,006,777)</td>
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<tr>
<td>1983-85</td>
<td>$16,833,044</td>
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<tr>
<td>1985-87</td>
<td>$38,219,952</td>
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<td>1987-89</td>
<td>$66,266,357</td>
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<tr>
<td>1989-91</td>
<td>$108,087,379</td>
</tr>
<tr>
<td>1991-93</td>
<td>$91,637,406</td>
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TOTAL SAVINGS
1981 TO 1993 $319,037,362
Senior and Disabled Services Division

Mission

"To serve older and disabled Oregonians through programs that encourage independence, dignity, and quality of life."
COMMON MISPERCEPTION OF OREGON LONG TERM CARE CONTINUUM

<table>
<thead>
<tr>
<th>NO ADL NEEDS</th>
<th>ADL NEEDS DEPENDENT</th>
<th>SUB ACUTE MED</th>
<th>ACUTE MED</th>
<th>RIP</th>
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<tbody>
<tr>
<td>1 2 3 4 5 6</td>
<td></td>
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START

32% 36% 30%

Home Care

30% 37% 33%

Adult Foster Homes

33% 32% 35%

Residential Care Facilities

37% 34% 29%

Assisted Living Facilities

22% 39% 38%

Nursing Facilities

FINISH
THE TRUTH  (E-GADS MARTHA! THERE IS NO CONTINUUM)

<table>
<thead>
<tr>
<th>NO ADL NEEDS</th>
<th>ADL NEEDS</th>
<th>SUB ACUTE MED</th>
<th>ACUTE MED</th>
<th>RIP</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>ASSISTANCE</td>
<td>DEPENDENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>11%</td>
<td>19%</td>
<td>19%</td>
<td>17%</td>
</tr>
</tbody>
</table>

- **Home Care**
  - 2%
  - 4%
  - 9%
  - 15%
  - 26%
  - 45%

- **Adult Foster Homes**
  - 3%
  - 11%
  - 20%
  - 24%
  - 23%
  - 20%

- **Residential Care Facilities**
  - 2%
  - 8%
  - 17%
  - 28%
  - 27%
  - 17%

- **Assisted Living Facilities**
  - 6%
  - 3%
  - 6%
  - 21%
  - 69%

- **Nursing Facilities**

START
ANYWHERE
(ALMOST)

FINISH
ANYWHERE
# Senior and Disabled Services Division

## 1993-95 Legislature Approved Budget

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<td>66.7</td>
<td>244,271,153</td>
<td>55.7</td>
<td>312,040,490</td>
<td>51.5</td>
<td>334,327,664</td>
<td>46.5</td>
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<td>23,861,729</td>
<td>12.1</td>
<td>74,453,353</td>
<td>17.0</td>
<td>135,629,993</td>
<td>22.4</td>
<td>193,159,395</td>
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<td>9,213,072</td>
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<td>9,712,315</td>
<td>1.6</td>
<td>9,986,234</td>
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<td>6,388,304</td>
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<td>138,900,127</td>
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<td>20,450,000</td>
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<td>Older Americans Act</td>
<td>15,929,732</td>
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<td>20,200,578</td>
<td>4.6</td>
<td>23,107,863</td>
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<td>24,256,963</td>
<td>3.4</td>
<td>5.0</td>
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<td>17,557,135</td>
<td>2.9</td>
<td>20,940,127</td>
<td>2.9</td>
<td>25,533,645</td>
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<td>25.3</td>
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<tr>
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<td>N/A</td>
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<td>79,371,574</td>
<td>11.1</td>
<td>33,382,164</td>
<td>5.5</td>
<td>30,178,316</td>
<td>4.2</td>
<td>(9.6)</td>
</tr>
</tbody>
</table>

**Total**                                     | 197,877,860    | 100.0             | 438,597,631    | 100.0             | 606,239,730    | 100.0             | 718,455,662                                   | 100.0             | 18.5                |

[1] Program Staff Included in Administration for 1991-93 and 1989-91

## Fund Sources

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<td>Other Funds Revenues</td>
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<td>3.9</td>
<td>25,861,410</td>
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<td>8.2</td>
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</table>

**Total**                                     | 197,877,860    | 100.0             | 438,597,631    | 100.0             | 606,239,730    | 100.0             | 718,455,662                                   | 100.0             | 18.5                |

## Program

### Nursing Facility Care
- **Cases:** 8,061
- **Cost Per Case:** 7,751
- **Total:** 7,518
- **Change:** -3.0%

### Community Based Care
- **Cases:** 5,088
- **Cost Per Case:** 12,059
- **Total:** 16,837
- **Change:** +39.6%

### Oregon Project Independence
- **Cases:** 3,400
- **Cost Per Case:** 3,470
- **Total:** 3,204
- **Change:** +7.7%

### Providence Elder Place
- **Cases:** N/A
- **Cost Per Case:** N/A
- **Change:** +61.9%

### Cash Assistance
- **Cases:** N/A
- **Cost Per Case:** N/A
- **Change:** +20.8%

### Total Cases
- **Cases:** 18,547
- **Cost Per Case:** 51,794
- **Total:** 62,042
- **Change:** +19.8%
Wisconsin Community Options Program
Overview of Major Programs and Funding Sources

We designed a state-funded program, the Community Options Program, which coordinates and "wraps around" all other funding in order to serve whole persons. The unit of funding in Community Options is "a person" rather than "a service." Before describing the Wisconsin Community Options Program in general, it may be helpful to discuss how the different funding sources inter-relate.

Wisconsin has four major funding sources for providing community care to persons of all ages who have substantial disabilities:

1. **Community Options Program (regular):** Enacted in 1981 with state-only funds, this program provides for comprehensive assessments, care planning, and completely flexible, on-going services for persons of all ages who meet nursing home admission requirements. Some persons require Community Options only for initial assessments and care planning since they may be adequately served thereafter by Medicaid HCBS waivers or Medicaid card services (see below). Most people, however, require some on-going state funds from the Community Options either because they are (a) ineligible for Medicaid, (b) eligible for Medicaid but not for a Medicaid HCBS waiver, or (c) eligible for a Medicaid HCBS waiver but require additional services which the waiver will not pay for (e.g. dentures and dental care, diapers, care management while hospitalized, etc.). The Community Option Program then, is the ultimate organizing and "wraparound" program which fills in the gaps and provides coordination for all other funding sources.

2. **Community Options Program-Waiver (COP-W):** The COP-Waiver is a Medicaid Home and Community-Based (HCBS) Waiver authorized under s.1915(c) of the Social Security Act. It provides funding for community care for persons in the Community Options Programs.

3. **Community Integration Program (CIP):** This is another Medicaid HCBS Waiver, identical to the COP-Waiver with one major difference: the number of people who can be served is determined primarily by the number of nursing home beds which have been closed and "de-licensed." In fact, the statute provides for the automatic creation of one CIP "slot" for every nursing home bed de-licensed. This means that persons can be relocated from nursing homes or ICF-MR facilities whenever they are ready, provided the bed is de-licensed after they leave (or another bed somewhere in the state is de-licensed). The statewide nursing home bed cap is reduced commensurately. The Community Integration Program is divided into 3 parts depending on the clientele and type of beds being de-licensed: (a) State Developmental Disabilities Institution beds, (b) ICF-MR facility beds, or (c) nursing facility beds. Since 1983 approximately 600 state institution beds, 200 ICF-MR beds, and 1,500 nursing facility beds have been closed and converted to Community Integration Program openings.

4. **Medicaid Care Services:** This is simply the term we use to describe the services under the state Medicaid plan which are normally available to an eligible person who has a Medicaid card. Supports such as home health, personal care, durable medical equipment, and drugs represent a
few examples. For persons on the Community Options Program or HCBS waivers, the Medicaid card pays for about 50% of their total community care.

Other sources of funding, such as Title III, Title XX, and SSI, are also relevant. They pay a proportionately smaller role in Wisconsin, however, due to the sizable investment of state-only and Medicaid dollars.
WISCONSIN COMMUNITY OPTIONS PROGRAM

VISION
Wisconsin Citizens will be supported to live in their own homes, in community, in the manner of their choosing.

VALUES
- Relationships
- Empowerment
- Services and Support
- Physical, Mental Health
- Enhance Reputations and Values
- Community Participation
- Tools for Independence

MISSION
- 10 Years
- To boldly go...

METHOD
- Get to Know People
- Individualize
- Support Whole Person
- Be User-Responsive

Questions: How will this next step become a stepping stone?
Question: What would be bold?

RESPECT

Bureau of Long Term Support, Wisconsin Department of Health and Social Services, 1994
BUREAU OF LONG TERM SUPPORT

MAY 13, 1988

To: PERSONS INTERESTED IN COP

WISCONSIN COMMUNITY OPTIONS PROGRAM

The Community Options Program is intended to target shrinking public resources toward elderly and disabled persons who are at greatest risk of entering nursing homes, and to make sure that reliable assistance is available to individuals who wish to stay in their own homes or communities. Eight counties began this program in 1982 with a gradual increase in participation every year. By 1986, all 72 Wisconsin counties were participating.

Below is a brief overview of the significant aspects of the Community Options Program. Additional information may be obtained from the Department of Health and Social Services, Bureau of Long Term Support, (608) 267-7284.

A. BACKGROUND INFORMATION

Most elderly and disabled persons prefer to receive help in their own homes for as long as possible. Until very recently, however, federal funds which match state Medicaid dollars 58% to 42% were restricted to maintenance in medically-related institutions, and limited payment for in-home care to nursing service. Until recently, federal funds were not available to provide in the home, all the care and services one could receive with federal matching funds in a nursing home.

In addition, while funding to assist persons living in their own homes required legislative review, approval, and consensus, expenditures for institutional care required review and consensus only when the relatively automatic increases were to be limited. The result is that the growth of institutional care has far outstripped the availability of community alternatives.

Despite public expenditures and mandates for a variety of community services, the nursing home population has grown at a disproportionately fast rate. The costs to state taxpayers for long-term care is now over 60% of the state's Medicaid budget, which in the last biennium totalled over one billion dollars.
Community service resources have been stretched to their limits supporting the elderly and disabled persons who have managed to stay in their own communities.

And finally, working connections between the community services network and the nursing home admission process have been too few and inadequate.

In response, the state initiated a two-part plan designed to begin to reverse this trend towards overuse of institutional care. The first part was a moratorium on the construction of new nursing home beds. This was necessary because increases in nursing home construction were claiming most of the available state monies for long-term support and there was no effective method, other than a moratorium, to control such growth. With the second highest rate of nursing home use in the country, Wisconsin is using the moratorium as time to "get its act together." The second part was the Community Options Program.

B. WHY DO WE NEED A COMMUNITY OPTIONS PROGRAM

First, people who are elderly or disabled prefer to remain in their own home or community rather than entering a nursing home or institution.

Second, the quality of a person's life is enhanced in the community through both formal and informal supports, and through opportunities for socialization, recreation and the exercise of both rights and responsibilities of citizenship.

Things which seem unimportant to most of us, can add significantly to the quality of an individual's life: to be able to decide what time and what to eat, what to wear, when to get up or go to bed, how loud to play your TV, who to spend time with, where to go to church.

Furthermore, presence in the community enriches not only the individual's life, but the life of the community itself. The natural support provided by family and friends is maximized. In filling gaps in these natural supports, COP creates employment opportunities in the community. Most importantly, the knowledge resources and abilities of elderly and disabled citizens are not wasted, but are available to the community.

Finally, COP allows the use of long-term support resources more cost-effectively. If COP can provide long-term support in a manner that is preferred by people, that improves the lives of individuals and the community, and which costs less, then it seems obvious that we do need COP.

C. ARE ALTERNATIVES CHEAPER THAN NURSING HOMES?

Yes. Alternatives such as care in one's own home can often save public dollars while using more private and volunteer support. Community care can also be much more expensive for some individuals. The Community Options Program is based on the premise that the average public cost for community alternatives is not any more than the average cost of nursing home care.
The Community Options Program manages the provision of services in a way that limits the average cost for all COP clients to an amount equivalent to the state's contribution to the daily rate of nursing home care for an individual. Ancillary medical services (therapy, pharmacy, physician) are about the same in either setting. In other words, the amount of COP money available for a person diverted from a nursing home is on the average no more than the amount the state would have paid if the person had gone to the nursing home as planned.

To the extent that community alternatives can provide service at a cost on the average less than that of nursing homes, it makes sense to use public money to pay for care where taxpayers want to receive it - in their own homes. The Community Options Program has demonstrated it can be one step toward a managed system of long-term support which will, within currently available and projected public resources, reduce our state's reliance on nursing home care.

We prefer, of course, to make the case for COP not just because it is more cost-effective, but more importantly because elderly and disabled people prefer living at home, it helps people to better maintain their independence and dignity, it increases the level of unpaid assistance from family and friends (1984 Department study) and it makes for more productive citizens.

D. ELEMENTS OF THE COMMUNITY OPTIONS PROGRAM

The Community Options Program provides the following kinds of help to elderly or disabled persons and their families:

1. Assessment

Every person planning to enter or at risk of entering a nursing home is first provided with a thorough review of his/her needs and capabilities to determine what assistance is needed in order to maintain the person at home. This review by professional persons, using interviews of the applicant as well as his or her family and friends, and examination of records, is called an assessment, and is required prior to admission to a nursing home. In addition, all current nursing home residents are eligible for a COP assessment. For current nursing home residents an assessment determines what would be necessary in order for them to return to their home communities. To date, more than 25,000 Wisconsin citizens have received a COP assessment.
2. Investigation of Possible Alternatives and Case Planning

The unique needs and abilities of each individual assessed are matched against the array of services and living arrangements available or potentially available in the community in order to see what alternatives to nursing home care are preferred by the person and are feasible. The capability of the individual and of caregivers, the public costs, the adequacy of available funds, and the willingness of everyone involved will determine the outcome of each case. The older/disabled person has the choice among the available options before a package of community care is planned. Services and living arrangements are organized and coordinated on an ongoing basis by a case manager.

3. Services

Depending upon income, services and living arrangements may be purchased, using COP funds to pay for any necessary goods or services not otherwise available to the person.

The COP assessment and the development of a plan for community care are both provided without charge for all COP-eligible persons. For many people who have reasonable private resources this assistance in planning, "packaging," and often contracting for home care may by itself make the difference between being able to remain at home or entering a nursing home. For low-income persons (eligible for Medical Assistance or likely to become eligible in six months if they entered a nursing home) the county Community Options Program will pay part or all of the necessary home care costs.

The amount of money available for COP services to an individual is the state share of the Medicaid nursing home reimbursement rate. For 1987, this amounts to an average of $603 per month. Some individuals could receive less than $603 and others more than the $603 average, depending on need and the availability of funds. In addition, SSI income supplements, Medicaid, home health, and other community services generally available continue to be available to each COP client. In other words, COP money is expected to fill the gaps in current community resources.

4. Other Features of the COP Program

Planning and Administration - One agency or caretaker, the county Department of Social Services, Unified Board or Human Services Department, has lead responsibility for implementing the program, under the authority of the county government to administer all aspects of the program. Development of the county plan, oversight, and quality assurance occurs through a planning committee in each county. This planning committee represents elected officials, consumers, health providers, and representatives of social services, elderly, developmental disabilities, physical disabilities, drug abuse and mental health programs.
Community Focus - Rather than asking "Who is inappropriate for nursing home care?" the Community Options Program asks: "What would it take for each person at risk of entering a nursing home to be served in their own community, and how can that happen for each individual?" The number of people who can appropriately be served in their own home is far greater than the number who might be called inappropriate for nursing home care. The key to helping people remain in their own homes is arranging for the necessary supports. Every COP assessment must result in an identification of "what it would take" (e.g., family support, paid services, volunteer services, etc.) to enable the person to continue (or begin) living at home or in a similar community setting.

E. FUNDING

State funds are appropriated and channeled to counties on a population and need-based formula which provides in 1987:

- up to $100 (based on individual county actual costs) per assessment for all persons seeking nursing home admission;

- an average of $180 per initial service plan for persons who are diverted from nursing homes and will remain in a community setting;

- funding to pay for services, living arrangements, or other elements of the individualized service plan.

State monies not necessary for assessment or case plan costs can be used by counties for services.

The total amount of funding provided to each county is roughly enough to assist two out of ten persons referred for nursing home placement to instead receive care in their own home or homelike residence. Counties are not under any obligation to serve more persons or provide more support than available funding allows.

In addition to these regular allocations, reserve funds have been set aside to assist counties to serve persons with a high level of needs, to serve underserved target groups, and in some cases to start up new programs. These funds are applied for and granted on an individual county basis.
REPORT TO THE LEGISLATURE

MEDICAID HOME AND COMMUNITY BASED SERVICES WAIVERS

COMMUNITY OPTIONS PROGRAM WAIVER
(COP-W)
COMMUNITY INTEGRATION PROGRAM II
(CIP II)

CY 1992

The following report is submitted to the Legislature pursuant to s. 46.277(5m) of the statutes and describes CY 1992 costs and services in Wisconsin’s Home and Community Based Services Waivers, CIP II and COP-W.

COP-W and CIP II provide Medicaid funding for home and community-based care for elderly and physically disabled citizens who have long term care needs and who would otherwise be eligible for Medicaid reimbursement in a nursing home.

Many community services are allowable under COP-W and CIP II. But the MA regulations and limits to Waiver funding leave some significant gaps in needed services. Consequently, it is critical that these programs be closely coordinated with the State’s Community Options Program (COP) in order to insure that individualized and comprehensive care is provided. The Medicaid Community Waivers provide Wisconsin residents who are elderly or disabled with a safe, consumer-controlled alternative to life in an institution. The Waivers also help to contain the costs of providing long term care to a fragile population.

COUNTY PARTICIPATION AND STATE ADMINISTRATION

CIP II and COP-W are administered by the Bureau of Long Term Support in the Division of Community Services. County participation in the Waiver programs was mandated effective 1/1/90 and all counties are actively participating. The annual census grew from 5,501 in 1991 to 6,129 persons served in 1992.
PARTICIPANT PROFILE

In 1992, CIP II and COP-W provided funding for home and community based services for 6,129 elderly and disabled people with long term care needs. The Medicaid Waiver participants are described below by target group, gender, marital status, level of care, living arrangement prior to Waiver participation and living arrangement under the Waiver.

<table>
<thead>
<tr>
<th>TARGET GROUP</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disabled</td>
<td>1,750</td>
<td>29</td>
</tr>
<tr>
<td>Elderly</td>
<td>4,379</td>
<td>71</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GENDER</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>1,922</td>
<td>31</td>
</tr>
<tr>
<td>Female</td>
<td>4,207</td>
<td>69</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MARITAL STATUS</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>1,955</td>
<td>32</td>
</tr>
<tr>
<td>Not Married</td>
<td>4,174</td>
<td>68</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LEVEL OF CARE</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICF (Intermediate Care)</td>
<td>3,242</td>
<td>53</td>
</tr>
<tr>
<td>SNF (Skilled Care)</td>
<td>2,887</td>
<td>47</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DIVERTED/RELOCATED FROM NURSING HOME</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relocations (New in 1992)</td>
<td>295</td>
<td>17</td>
</tr>
<tr>
<td>Diversions (New in 1992)</td>
<td>1,444</td>
<td>83</td>
</tr>
<tr>
<td>(Existing relocations/diversions = 4,390)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LIVING ARRANGEMENT</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Own home</td>
<td>2,122</td>
<td>35</td>
</tr>
<tr>
<td>With family/others</td>
<td>3,503</td>
<td>57</td>
</tr>
<tr>
<td>Adult family home</td>
<td>72</td>
<td>1</td>
</tr>
<tr>
<td>Supervised apartment</td>
<td>62</td>
<td>1</td>
</tr>
<tr>
<td>Community-based residential facility</td>
<td>370</td>
<td>6</td>
</tr>
</tbody>
</table>
MEDICAID WAIVER SERVICE PROVISION AND COSTS

Medicaid Waiver participants utilize the allowable services for which the State requests federal authorization through its MA Waiver application, as well as those services traditionally available to all Medical Assistance recipients as authorized by the federal government through approval of the State’s Medicaid Plan. State Plan services are those which are provided to all Medical Assistance recipients having a Medical Assistance card. The Waiver services are generally non-medical in nature and the State Plan (MA card services) are generally those needed for medical care. Since the Medicaid Waiver programs must look at all Medicaid costs, the expenditures for both sets of services are combined to determine total Medicaid Waiver costs.

The specific Waiver services which participants used in 1992 represent 48% of the total MA costs to the Waiver program. The remaining 52% of costs were incurred through use of the participants MA card to secure medically-related services such as drugs, physician services, therapies, home health services, etc. The non-medical Waiver services provided, their utilization by Waiver participants and the total costs for each service are outlined below. Additionally, the total cost for the MA card services used by participants is added to the Waiver services. The sum represents the total 1992 Medicaid CIP II/COP-W expenditures for the 6,129 persons served.

1992 MA WAIVER SERVICE UTILIZATION

<table>
<thead>
<tr>
<th>SERVICE CATEGORY</th>
<th>% OF PARTICIPANT UTILIZATION</th>
<th>COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Management</td>
<td>90%</td>
<td>$4,280,241</td>
</tr>
<tr>
<td>Supportive Home Care</td>
<td>94%</td>
<td>30,425,720</td>
</tr>
<tr>
<td>Respite Care</td>
<td>4%</td>
<td>422,091</td>
</tr>
<tr>
<td>Habilitation</td>
<td>3%</td>
<td>379,486</td>
</tr>
<tr>
<td>Adult Day Care</td>
<td>8%</td>
<td>1,491,324</td>
</tr>
<tr>
<td>Transportation</td>
<td>13%</td>
<td>536,414</td>
</tr>
<tr>
<td>Home Modification: Adaptive Equipment, Aids, Devices</td>
<td>45%</td>
<td>1,512,434</td>
</tr>
<tr>
<td>Total Waiver Service Costs</td>
<td>--</td>
<td>$39,047,710</td>
</tr>
</tbody>
</table>
### 1992 MA WAIVER CARD SERVICE UTILIZATION

<table>
<thead>
<tr>
<th>MA CARD SERVICE CATEGORY</th>
<th>% OF PARTICIPANT UTILIZATION</th>
<th>COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital</td>
<td>4%</td>
<td>$2,114,890</td>
</tr>
<tr>
<td>Physician</td>
<td>74%</td>
<td>1,026,858</td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>51%</td>
<td>1,513,753</td>
</tr>
<tr>
<td>Lab and X-ray</td>
<td>55%</td>
<td>251,577</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>93%</td>
<td>7,477,553</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>48%</td>
<td>2,096,224</td>
</tr>
<tr>
<td>Transportation</td>
<td>41%</td>
<td>2,273,919</td>
</tr>
<tr>
<td>Therapies</td>
<td>5%</td>
<td>394,876</td>
</tr>
<tr>
<td>Respiratory Care</td>
<td>&lt;1%</td>
<td>381,490</td>
</tr>
<tr>
<td>Dental Services</td>
<td>17%</td>
<td>186,193</td>
</tr>
<tr>
<td>Nursing</td>
<td>&lt;1%</td>
<td>127,802</td>
</tr>
<tr>
<td>Home Health and Personal Care</td>
<td>58%</td>
<td>24,265,866</td>
</tr>
<tr>
<td>Other</td>
<td>33%</td>
<td>481,852</td>
</tr>
<tr>
<td><strong>Total MA Card Service Costs</strong></td>
<td>--</td>
<td><strong>$42,592,853</strong></td>
</tr>
</tbody>
</table>

---

| Total Waiver Service Costs            | $39,047,710               |
| Total MA Card Costs                   | $42,592,853               |
| **TOTAL 1992 MEDICAID EXPENDITURES FOR CIP II/COP-W PARTICIPANTS** | **$81,640,563** |
TOTAL PUBLIC FUNDING AND COST COMPARISON OF MEDICAID WAIVER AND MEDICAID NURSING HOME CARE

In addition to Medicaid funded services many waiver participants are recipients of other public funds, some of which supplement the individual’s long term care costs. To demonstrate a cost comparison of persons participating in the Medicaid Waiver versus those whose long term support needs are met through nursing home care, an analysis was completed to report the total public funding attributable to each group.

Table 1 below depicts total public funds on an average per day basis for nursing home and Waiver care. It also contains a breakdown of the federal contribution and the state and/or county contribution of each source of funding.

<table>
<thead>
<tr>
<th>Funding Source</th>
<th>MA Waiver</th>
<th>Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>State/Co</td>
</tr>
<tr>
<td>A. Medicaid</td>
<td>50.16</td>
<td>19.60</td>
</tr>
<tr>
<td>B. SSI</td>
<td>4.70</td>
<td>2.40</td>
</tr>
<tr>
<td>C. COP</td>
<td>1.23</td>
<td>1.21</td>
</tr>
<tr>
<td>D. Community Aids</td>
<td>.08</td>
<td>.06</td>
</tr>
<tr>
<td>E. Other</td>
<td>.09</td>
<td>.01</td>
</tr>
<tr>
<td>F. TOTAL</td>
<td>56.26</td>
<td>23.28</td>
</tr>
</tbody>
</table>

*Unknown

Exhibit 1, which follows, depicts a comparison of average daily, per capita waiver cost versus average daily, per capita nursing home cost.
Average Daily Public Cost* for Nursing Home and MA Waiver Participants in the Community Options Program

*Includes all public costs such as MA State Plan Services, MA Waiver, Title XX, Title III, SSI, Federal rent subsidies, etc., for COP-W/CIP II Participants

When all public costs are counted, expenses for MA Waiver participants averaged $56.26 per person per day, compared to $67.11 per day for care in nursing facilities. Community care, on average yielded a 16% cost savings.

The total public cost of care for waiver participants in CY 1992, based on the actual days of Waiver service was $91,572,320. Had Waiver recipients spent the same number of days in nursing home care the cost would have been $109,232,464.

Thus, it is estimated that CIP II/COP-W utilization in 1992 resulted in a total savings or reduction in public spending of $17,660,144.
Reducing Institutional Cost
Through Lower Use

- **Construct** a Real Community Care System
- **Control** Nursing Home Supply and Use
- **Convert** Institutional Funds
  - Institutional to Community
  - Fixed to Portable
- **Calculate** Your Savings and **Convince** Officials
- **Convey** Savings to Community Programs

Real Community Care Helps Control
Institutional Use

- Lowers Nursing Facility Occupancy and Facilitates Downsizing
- Harness Advocacy Energy
  - Oppose Institutional Expansion Vigilantly
  - Promote Downsizing
- Inspire Individuals, Caregivers, Families
  - Living At Home Is Possible
  - A Little Help Goes A Long Way
- Inspire Public Officials
Convert Institutional Funds to Community

- State Statute: Each Closed Bed Automatically Yields HCBS Waiver Slot (Voluntary)
  - State Developmental Disability Centers
  - County-Owned Nursing Homes
  - Private Nursing Homes

- State Statute: Annual Transfer of Savings

- Nursing Home Reimbursement Formula
  - Penalize Low Occupancy (Rates and MA Bed-Hold)
  - Downsizing Protection up to 18 Months

- Community Fund to Buy Facilities and Close Them?

Control Nursing Home Supply and Use

SUPPLY
- Nursing Home Bed Caps
  (NF and ICF-MR)
- Bed Caps Cannot Be Raised Without New Legislative Appropriation
- New Bed Applications Must Show Infeasibility of Community Care
- Bed caps Are Reduced By Community Conversions
- Replacements and Reallocations Underneath the Bed Caps

USE
- Nursing Home Eligibility Criteria
- Nursing Home Preadmission Screening (Phased Out)
- Community Alternatives
- Hospital Link Projects
Change in MA-Funded Days of Care in SNF / ICF Facilities
FFY 1980/81 v. 1990/91

Source: Betz/Hamilton (HCFA 2002) Wisconsin DHSS

Wisconsin Compared to Other Midwest States
Percent Change in MA-Funded Days of Care in SNF / ICF Facilities
FFY 1980-81 v. 1990-91

Indiana  Missouri  Ohio  National Avg.  Kansas  Illinois  Iowa  Minnesota  Michigan  Wisconsin
-17.3%  4.0%  -3.7%  -2.1%  1.2%  6.5%  33.1%  40.6%  66.3%  227.0%